STATE EMPLOYEES' LEAVE BANK
MEDICAL REQUEST FORM

1. DATE: _____/_____/_____

2. PATIENT'S NAME: _____

3. DATE OF BIRTH:_____/_____/_____ SEX:_____

4. JOB CLASSIFICATION: _____

5. DIAGNOSIS: (Statement)_____

_____

_____

Provide International Classification of Diseases Code(s) (ICD-9):

_____ _____ _____

6. Approximate date employee should return to:

a. Modified Activities/Duty _____/_____/_____ b. Full Activities/Duty_____/_____/_____

7. Summary of Treatment and anticipated procedures (attach additional sheets, if necessary):

_____

_____

_____

8. Treatment according to Certified Procedure Terms (CPT) Code(s):

_____ _____ _____

9. Please provide detailed information as to what aspect(s) of the position the employee is unable to perform. (Attach additional sheets, if necessary.)

_____

_____

10. Physician's Name: _____

(PRINTED OR TYPED)

_____ _____

(PHYSICIAN'S SIGNATURE) *(PHONE NUMBER)*

Note: This document shall be treated as a confidential medical record and not placed in the employee's personnel file. Only those individuals with a need to know the information contained in this document, to evaluate and review this request will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this document may be subject to disciplinary action, including termination, as well as any other liability imposed by law.

ALL SECTIONS MUST BE COMPLETED IN ORDER FOR THE REQUEST TO RECEIVE FULL CONSIDERATION.